STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 11, 12, 13, 14, 15, 18, and 19, 2011 Facility number: 000195 Provider number: 155298 AIM number: 100267690 Survey team: Connie Landman RN TC Diana Zgonc RN Christi Davidson RN Courtney Hamilton RN Census bed type: SNF/NF: 92 Total: 92 Census payor type: Medicare: 10 Medicaid: 62 Other: 20 Total: 92 Stage 2 Sample: 29 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and/or execution of this plan of correction in general, or any corrective action does not consittute an admission or agreement by Cambridge Manor Healthcare and Rehabilitation Center of the facts alleged or the conclusions set forthe in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed soley because of the provision of Federal or State laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 7/25/11 Cathy Emswiller RN			
F0226 SS=C	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to provide an abuse policy with the correct guidance on reporting. This deficient practice had the potential to affect 92 of 92 residents currently residing in the facility. Findings include: An undated facility policy titled, "Abuse Protection and Response Policy," provided by the Administrator on 07/11/11 at 10:30 a.m., indicated, "...VII. Reporting And Response Issues: 1. POLICY: All reports of abuse or alleged abuse will be immediately assessed to determine the direction of the investigation. 2. PROCEDURE: Any investigation that substantiates abuse or neglect or alleged abuse or neglect findings will be reported immediately to the Administrator or his/her designated representative and to other officials in accordance with State Law within 5	F0226	Element #1What corrective actions will be accomplished for those residents found to have been affected by the deficient practices?It is the policy of this facility to see that all reports of abuse/neglect or alleged abuse/neglect are reported immediately to the Administrator or his/her designee. All such events will be thoroughly investigated. Further, the event is reported to the ISDH within 24 hours of the event. The faclity also does a 5 day follow up report to the ISDH if all necessary reportable information was not yet available within the first 24 hours. The facility is using the QIS manual's policy and procedure for Abuse/Neglect reporting.Element #2How other residents having the potential to be affected by the same deficient paractice will be identified and what corrective actions will be taken?All residents have the potential to be affected by this finding. Going forward, the staff will report any event of abuse/neglect to their supervisor or the charge nurse, who will immediately notify the administrator or his/her designee	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	working days of the event...." The abuse policy lacked documentation of reporting to the Administrator and/or his/her designated representative, and the abuse policy lacked documentation to reflect the Indiana State Health Department would be notified within 24 hours after discovery of the incident. During an interview, on 07/19/11 at 10:21 a.m., the Administrator indicated the policy titled, "Abuse Protection and Response Policy" was the current facility policy in regards to abuse or allegations of abuse. 3.1-28(c)(2)		so that the proper protocol can be initiated at once. Further, all such events or alleged events will be reported to the ISDH within 24 hours. All events of this type will be listed by the charge nurse on the 24 hour report so that the DON or designee can check to see that all proper protocol was followed timely and accurately.Element #3What measures will be put into place or what sytematic changes will be make to ensure that the deficient practice does not recur?At an all staff inservice held on Tuesday 8/9/2011, the policy and procedure on abuse/neglect was reviewed. This includes the timely reporting of all events of abuse/neglect and alleged abuse/neglect. The administrator is to be immediately notified and the ISDH is to be notified within 24 hours. All points of the QIS manual's abuse/neglect policy were reviewed and will be followed. Any staff who fail to comply with the points of the inservice will be further educated and progressively disciplined as appropriate. The facility has a zero-tolerance policy in regards to abuse/neglect or failure to report such instances.Element #4How the corrective actions will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place?At the monthly Quality Assurance meeting all of the tracking of the 24 hour reports	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			by the DON or designee will be reviewed as well as all reports of abuse/neglect or alleged abuse/neglect to see that all reporting protocols have been followed timely. Any concerns will be immediately addressed. If necessary, an action plan will be written by a commitee appointed by the Administrator. This plan will be monitored weekly until resolution. Again, no abuse/neglect or failure to report such instances will be tolerated.	
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview the facility failed to respect the dignity of a resident with a gastric tube (G-tube) by pulling up the shirt to connect the tube feedings in the hallway for 1 resident of a stage two sample of 29. (#33) Findings include: The record for Resident #33 reviewed on 07/15/11 at 1:58 p.m. Diagnoses included, but were not limited to aphasia and acute respiratory failure. A Social Service Progress note dated 05/04/11 indicated Resident #33,	F0241	Element #1What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to see that each residents care is administered in an environment of dignity and respect. Resident # 33 has dignity maintained at all times. Resident #33 does not have their shirt raised to care for or work with their feeding tube unless the setting is completely private and dignified. Exactly what is to be done with the resident is explained to the resident prior to the care being administered. Element # 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?Any	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...unable to communicate..." The most recent recapitulation dated 07/01/11 through 07/31/11, indicated Resident #33 was NPO (nothing by mouth). The most recent recapitulation dated 07/01/11 through 07/31/11, with an original physician's order dated 06/23/11, indicated, "...All med per G-tube and liquid where possible...." The most recent recapitulation dated 07/01/11 through 07/31/11, with an original physician's order dated 05/24/11, indicated, "Jevity 1.5 cal (calories) at 60cc/hr (cubic centimeter per hour) from 2pm - 10 am...." A care plan title "Feeding Tube," dated 06/23/11 indicated, "Resident has a need for use of a feeding tube...Resident will remain free of complications related to use of a feeding tube...Check residual prior to resuming any enteral feeding, (that has been turned off for 1 hr or greater)...Educate resident/responsible party regarding feeding tube...Self-image." During an observation on 07/14/11 at 1:35 p.m., LPN #14 asked CNA #15		resident who has a feeding tube has the potential to be affected by this finding. A targeted list was made of all residents who have feeding tubes. All of these residents who are interviewable were interviewed as to dignity concerns during care or use of their feeding tubes. Any concerns were addressed. Going forward, all residents with feeding tubes will be monitored at least three days weekly during tube related care to see that dignity is maintained. Any concerns will be addressed immediately. This monitoring will be done by DON or designee on various shifts and will continue until 4 consecutive weeks of zero negative findings are realized. Then, random weekly checks will continue. Element # 3What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?At an all staff inservice held 8/9/11 Resident Rights and Dignity policies were reviewed. Special emphasis was placed on maintaining dignity during care and or use of a feeding tube. Issues of draping, privacy, and unecessary skin exposure were covered. Any staff who fail to follow the points of the inservice will be further educated and or progressively disciplined as appropriate. Element # 4How the corrective action(s) will be monitored to ensure the deficient practice will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to bring the feeding pump out in the hall with Resident #33, so the tube feedings could be initiated at 2:00 p.m. During an observation on 07/14/11 at 2:00 p.m., Resident #33 was in the hallway on the second floor by the nurses station. The feeding pump and pole were next to the resident. The feeding tube was not connected to Resident #33, and the feeding was not running. During an observation on 07/14/11 at 2:35 p.m., LPN #14 lifted Resident #33's shirt while he remained in the hallway and connected the tube feeding to the G-tube and started the feedings. During an interview on 07/14/11 at 2:40 p.m., LPN #14 indicated, "I know I shouldn't have done that. I should have taken him back to his room." During an interview on 07/15/11 at 10:55 a.m., CNA #15 indicated the nurse asked him to bring the feeding pole out with the resident so they could start the tube feedings around 2:00 p.m. A current facility policy provided by the Administrator on 07/14/11 at 9:00		not reoccur, i.e., what quality assurance program will be put into place?At the monthly Quality Assurance meetings the result of the feeding tube dignity monitoring will be reviewed. Any concerns will have been addressed and corrected immediately upon discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a.m., titled, "Tube Feedings, Gastrostomy/Jejunostomy," indicated, "...8. Expose G/J (gastrostomy or jejunostomy) tube and drape with towel. NOTE: Do NOT unnecessarily expose the Resident...10. Verify tube placement via aspiration of gastric/jejunal content with a feeding syringe, re-installing content aspirated, or via (by way of) auscultation of air bolus...." A current facility policy provided by the Administrator on 07/14/11 at 9:00 a.m., titled, "Tube Feeding Closed System Protocol," indicated, "...2. Provide privacy and explain procedure to the resident...." 3.1-44(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview and record review the facility failed to develop complete and accurate assessments for 2 residents in a stage two sample of 29 residents. (#88, #38) Findings include: 1. The Record for Resident #88 was	F0272	Element #1What corrective action(s) will be accomplished for the those resdients found to have been affected by the deficient practice?It is the policy of this facility to conduct initial and periodic assessments that are comprehensive and accurate and revealing of the residents functional capacity in multiple specified areas. Resident # 88 no longer resides.Resident # 38	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 07/14/11 at 12:35 p.m. Diagnoses included, but were not limited to, cerebral vascular accident, hypertension, diabetes, osteoarthritis, pain, and seizures. A Resident Data Collection form, dated 05/10/11, indicated Resident #88 had mild pain in the left thigh, leg, and ribs. This admission data indicated Resident #88 had pain on admission. The document lacked the assessment of pain and failed to assess the frequency, intensity or causes of pain. A care plan dated 05/10/11 indicated a potential for pain related to osteoarthritis. Interventions included were, but not limited to, "...Administer medications as ordered...Assess for pain...Encourage exercise...Gentle range of motion...PT/OT (physical therapy/occupational therapy) evaluate...." A Physical Therapy note dated 05/10/11 for initial assessment, indicated Resident #88 has chronic pain in left arm. A physician's progress note dated 05/24/11 indicated Resident #88 had pain.		has had a complete and thorough assessment for dietary issues which includes likes and dislikes. Resident # 38 will continue to be assessed periodically for dietary needs. Likes and dislikes and weight concerns will be included. Element # 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents who have concerns with pain or dietary issues could be affected by this finding. A "look-back" audit was done on all residents who receive pain medications to be sure the pain is defined as much as possible as to cause, intensity, frequency, and interventions to control the pain. Periodic pain assessments will continue on all residents who recieve pain medication to be certain appropriate interventions are in place to keep pain controlled and to improve life quality for the resident. A "look-back" audit was done facility wide to see that all resdients have had a recent (within last quarter) dietary assessment that addressess any dietary issues including any concerns with weight loss or gain, open areas, food preferences, special diet needs and any other resident specific diet issues. All necessary interventions will be implemented to meet the dietary need. Periodic assessments will continue on all residents to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Pain Assessment Sheet undated and untimed, indicated Resident #88 was a 4 out of 10 on the pain scale. The assessment questions on the back of the pain assessment sheet were unanswered. During an interview on 07/12/11 at 2:20 p.m., Resident #88 indicated, "My ribs hurt all the time from when I fell last year." During an interview with the Administrator on 07/15/11 at 4:00 p.m., documentation of a pain assessment for Resident #88 was requested. On 07/18/11, at 2:00 p.m., the Charge Nurse #16 provided a copy of the pain assessment sheet, previously noted in the record, and the Resident Data Collection form previously noted in the record. No further documentation for a pain assessment for Resident #88 was provided. An undated facility policy provided by the Administrator on 07/19/11 at 11:12 a.m. The Administrator indicated this policy was the current policy for pain assessment. The policy titled, "Pain Management," indicated, "...A		assure all appropriate intervientions are in place for any dietary need that develops. The DON or designee will review 10 charts weekly to see that all appropriate assessments have been done based on recent documentation in nurses notes, lab/x-ray results, falls, dietary issues behaviors, skin issues, weight loss issues, or any other findings which would indicate a need for an assessment to be done. If there is a needed assessment, it will be completed. This monitoring will continue until 4 consecutive weeks of zero negative findings (all assessments done as appropriate) are realized. Afterwards, random weekly monitoring of assessments will be done. Element # 3What measures will be put into place or what systemic changes will be made to ensure that one deficent practice does not reoccur?At an all staff inservice held 8/9/11, the policy and procedure on assessments was reviewed. The following was discussed: a. Why do an assessment? b. When is an assessment necessary? c. Who can do an assessment? d. Assessment results as related to care plan development. e. Assessments as related to MDS process. f. DiscussionAny staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as necessary.Element	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident is assessed for pain based on: 1. Complaint of pain communicated verbally. 2. Diagnosis of a condition known to cause pain...." The second page of the policy included a "Brief Pain Inventory" form. A blank Pain Assessment form was provided with the policy. **#2.** Residenti#38 ' s record was reviewed on 07/14/2011 ati12:35 P.M.. Diagnoses included buti were noti limitied tio lefi parotitis, multiple sclerosis, ostieoartihriti,depression, and a non-healing righti ankle ulcer. A currenti physicians order datied 06/13/2011 indicatied residenti was tio receive a mechanical sofi dieti witih regular liquids and tiube fieeds at75 millilitiers/hour firom7 P.M. tio5 A.M. An intierview witih resident#38 on 07/15/2011 ati1:25 P.M. indicatied tihe fiacilitiy had never asked her whati her fiood prefierences wereShe indicatied tihe lunch was noti very good and she did noti enjoy tihe fish sticks she was served She had consumed 25% ofi tihe meal. A current care plan updated 06/11/2011 indicated "...resident remains at risk for unplanned weight		# 4How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place;?At the monthly Quality Assurance meetings the assessment monitoring by the DON or designee will be reviewed. Any patterns will be identified. If necessary, an action plan will be written by a committee appointed by the administrator. The plan will be monitored by the administrator weekly until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	loss, leaves 25% of meals uneaten." Interventions included "...honor food preferences." Food intake records for June 2011 indicated resident consumed on average 50% of most meals. A medical nutrition therapy monthly review dated 06/10/2011 indicates resident should receive pleasure foods. The record lacked documentation of a dietary assessment of resident #38's likes or dislikes. An interview with the Dietary Manager on 07/18/2011 at 1:10 P.M. indicated there was no dietary assessment completed prior to 07/18/2011. A current facility policy dated 2008, provided by the Administrator 07/19/2011 at 11:10 A.M., titled, "Medical Nutrition Therapy Documentation" indicated ... " initial assessment... will include information on... food preferences..." 3.1-31(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview the facility failed to ensure care plans were completed for residents with pressure ulcers and activities of daily living for 2 of 29 residents reviewed for care plans (Resident # 59, # 40) Findings include: 1. A current undated facility policy titled "Care Plan" and provided by the Administrator on 7/19/11 at 11:00 A.M. indicated, "Purpose of the Care Plan An interdisciplinary Care Plan provides the guidance to all staff caring for the resident and communicates changes in	F0279	Element # 1What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facilty to see that all residents have a comprehensive plan of care based on the result of accurate and timely assessments.Resident # 59 currently has a care plan which addressess their skin issues and has appropriate interventions in place to promote healing of skin and improve quality of life. Resident # 40 currentlly has a care plan which addressess all ADLs (Activities of Daily Living). All appropriate interventions are in place to promote as much independence and well-being as possible for the resident. Element	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care. Policy All residents must have a Care Plan. Updating Care Plan The interdisciplinary Care Plan is reviewed, revised and updated quarterly and more frequently if warranted by a change in resident's condition. Initiating the Resident Care Plan The resident care plan is initiated at the time of admission. 2. The record for Resident # 59 was reviewed on record review 7/18/11 at 1:00 P.M. The resident was admitted on 6/3/11 with pressure ulcers. Diagnoses for Resident # 59 included but were not limited to decubitus ulcer, hyperglycemia, Diabetes and respiratory failure. The admission assessment of 6/3/11 indicated the resident had pressure ulcers on both heels, right lateral ankle and the coccyx/sacral area.		# 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this finding. A 30 day " look-back" audit was done facility wide on all residents to be certain any skin concerns or ADL (Activity of Daily Living) concerns are care planned. Any concerns will be addressed immediately. Theses monitorings will continue until 4 consecutive weeks of zero negative findings are realized. Afterwards, random weekly monitorings be done. Element # 3What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?At an all staff inservice held 8/9/11 the importance of a comprehensive care plan based on assessments was discussed. The care plan policy was reviewed. Emphasis was placed on the need for care plans with appropriate interventions for any skin issues or ADL needs of any resident. Any staff who fail to comply with the points of the inservice will be further educated and or progressivley disciplined as appropriate.Element # 4How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place;?At the monthly Quality Assurance meetings the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record lacked documentation of an interim care plan or current care plans that indicated interventions, pressure ulcers resolved or any new or changed treatments for Resident #59's pressure ulcers. During an interview with the 3rd floor ADON on 7/18/11 at 2:35 P.M., care plans for the resident's pressure ulcers were requested. During an interview with the 3rd floor ADON on 7/18/11 at 3:30 P.M. she indicated there were care plans but she could not find the originals so she redid them. #3. Resident #40's record was reviewed on 07/15/2011 at 9:20 A.M.. Diagnoses included but were not limited to hypertension, expressive aphasia, vascular dementia, dysphagia, coronary artery disease, and psoriasis. A current care plan last updated 07/13/2011 indicated "...potential for complications related to dx {diagnosis) of coronary artery disease...risk for decline in ADL's [activities of daily living]..." Approaches listed addressed the complications related to coronary artery disease. The record lacked documentation		monitoring results of the DON or designee as related to care plans and ADLs will be reviewed. Any patterns will be identified. If necessary, an action plan will be written by a committee appointed by the administrator. The plan will be monitored weekly until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of approaches to address the residents decline in ADL's. An interview with CNA #1 on 07/15/2011 at 10:20 A.M., indicated resident is able to help wash her face but she is dependent on staff for her ADL's. An interview with the DON on 07/18/2011 at 9:30 A.M., indicated there was no ADL care plan and stated that every resident should have one. 3.1-35(b)(1)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to ensure physician orders were followed for the use of side rails and medication administration. This affected 2 of 29 residents reviewed for physician orders in a sample of 29. (Resident #38, Resident #39) Findings include: #1. Residenti#38 ' s record was reviewed on 07/14/2011 ati12:35 P.M.. Diagnoses	F0282	Element # 1What correct actions will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of the facility to see that services are provided by qualified persons in accordance with the residents plan of care. Currently resident # 38 has the use of side rails as per physician order, assessment, and care plan. Currently resident # 39 receives all medications as per physican order. These medications have all be clarified with the physican. Currently resident # 38 has the use of low	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included buti were noti limitied tio lefi parotitis, multiple sclerosis, ostieoartihritis depression, and a non-healing righti ankle ulcer. A current physicians order dated 05/26/2011 indicated resident was to have "...full side rails both sides..." A care plan updated 05/28/2011 indicated the use of full side rails. A current multidisciplinary therapy screening dated 06/27/2011 indicated resident is non compliant with asking for help and requires a low bed, alarms and mats. The record lacks documentation of the presence of side rails. Observation of resident #38's room on the following dates: 07/11/2011-07/15/2011 indicated resident did not have full side rails on the bed. The record lacked documentation of a physicians order to discontinue the side rails. An interview with the DON on 07/18/2011 at 9 A.M., indicated the facility had been working hard to discontinue the use of side rails and had done so for several residents in		bed, matts, and tubular bolsters on bed. This is per physican order and assessment. Element # 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All resdients have the potential to be affected by these findings. A facility wide audit was completed to be certain that all residents who have orders for siderails have an assessment in place which indicates a medical need for the siderail. Further, if the resident does have an order and medical need for a siderail(s) this is care planned and monitored per policy and state/federal regulations. The facility tries to use siderails only when absolutely necessary due to safety concerns.All residents were audited to see if they were using siderails. If they were, all protocols were completed per policy and state/federal regulations. Any concerns were addressed.A facility wide audit was completed to ensure that all residents were receiving all of the medications ordered for them. Any concerns were immediately addressed.The DON or designee will monitor 10 charts weekly to see that siderail useage or non-usage is corrected and being implemented only per policy/procedure. Also, 10 charts will be monitored to see that all medications are being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the facility. She indicated there was no physicians order to discontinue the side rails. 2. The record of Resident #39 was reviewed on 07/18/11 at 5:00 p.m. Diagnoses included were, but not limited to, hypertension, dementia with delusions, chronic renal insufficiency, and osteoarthritis. A current recapitulation dated 07/01/11 through 07/31/11, with a physician's order with an original date of 06/03/11, indicated, "Metoprolol Tartrate (hypertension medication) 25mg Tab...Give 1 tablet by mouth twice daily...." A Medication Administration Record (MAR) dated 07/01/11 through 07/31/11 indicated Resident # 39 was scheduled to receive Metoprolol Tartrate 25mg at 9:00 a.m. daily. During a medication observation on 07/15/11 at 9:00 a.m., LPN #12 did not administer Metoprolol Tartrate 25mg at 9:00 a.m. to Resident #39. A MAR dated 07/01/11 through 07/31/11 indicated the last dose of Metaprolol Tartrate 25mg was given at 9:00 a.m. on 07/10/11. The MAR has		administered according to current physican orders. Any concerns found on these monitorings will be immediately corrected. These monitorings will continue until 4 consecutive weeks of zero negative findings are reallized. Afterwards, random weekly checks will be done. Element # 3What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?At an all staff inservice held 8/9/11 the policy and proceedure for siderails was reviewed. The following was covered: a. Siderail safety b. Siderail order (what, where, when) c. Siderail assessment/ care plan d. Medical need e. Consent/ Waiver f. Flow sheet g. CNA assignment sheet h. Education on siderails (resident and family) i. DiscussionAlso at the inservice the necessity of administering only ordered medications and all ordered medications was reviewed. The policy and procedure for taking a medication order was reviewed. This includes: a). Receiving order b). Checking allergies c). Placing on medication sheet/treatment sheet d). Ordering medication e). Following up on meedication f). Proper notifications g). Stop date (if known) h). Discontinuance of a medication i). Returning medications if appropriate j).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a line through the date 07/11/11 and a handwritten note, "SEE NEXT PAGE NO PARAMETERS ORDE {SIC}...." Page two or page three of the current MAR did not have the medication listed. Yellow highlight was drawn over Metaprolol Tartrate 25mg. During an interview on 07/18/11 at 5:00 p.m., LPN #13 indicated she was not aware of why the medication had not been given. She indicated it appeared discontinued because of the highlight. During an interview on 07/18/11 at 5:05 p.m., the second floor ADoN indicated she was not aware of why the medicine appeared to be discontinued. During an interview on 07/18/11 at 5:15 p.m., the DoN indicated she would investigate the issue of the medication. A new physician's order dated 07/18/11 at 5:28 p.m., indicated an order clarification for Metaprolol Tartrate 25mg for Resident #39. 3.1-35(g)(2)		Destruction of medication (actual medication on MAR) k). DiscussionAny staff who fail to comply with the points of this inservice will be further educated and or progressively disciplined as appropriate.Element # 4How the corrective action(s) will be monitored to ensure that deficient practice will not reoccur, i.e., what quality assurance program will be put into place;?At the monthly Quality Assurance meetings the results of the siderail and medication adminstration monitoring by the DON or designee will be reviewed. Any concerns will have been corrected upon discovery. Any patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The plan will be monitored weekly by the administrator until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to ensure physician orders were followed for the use of side rails. This affected 1 of 29 residents reviewed for side rails in a sample of 29 (Resident #38). Findings include: #1. Residenti#38 ' s record was reviewed on 07/14/2011 ati12:35 P.M.. Diagnoses included buti were noti limitied tio lefi parotitis, multiple sclerosis, ostieoartihritis, depression, and a non-healing righti ankle ulcer. A current physicians order dated 05/26/2011 indicated resident was to	F0309	Element # 1What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of the this facilty to see that all residents receive the necessary care and treatment to maintain the highest level of overall well-being. Currently Resident # 38 has the use of low bed, matts, tubular bolsters, on bed. This is per physican order and assessments.Element # 2How other residents having the potential to be affected by the same deficient practive will be identified and what corrective action(s) will be taken?All resdients have the potential to be affected by these findings. A facility wide audit was completed to be certain that all residents	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	have "...full side rails both sides..." A care plan updated 05/28/2011 indicated the use of full side rails. A current multidisciplinary therapy screening dated 06/27/2011 indicated resident is non compliant with asking for help and requires a low bed, alarms and mats. The record lacks documentation of the presence of side rails. Observation of resident #38's room on the following dates: 07/11/2011-07/15/2011 indicated resident did not have full side rails on the bed. The record lacked documentation of a physicians order to discontinue the side rails. An interview with the DON on 07/18/2011 at 9 A.M., indicated the facility had been working hard to discontinue the use of side rails and had done so for several residents in the facility. She indicated there was no physicians order to discontinue the side rails. 3.1-35(g)(2)		who have orders for siderails have an assessment in place which indicates a medical need for the siderail. Further, if the resident does have an order and medical need for a siderail(s) this is care planned and monitored per policy and state/federal regulations. The facility tries to use siderails only when absolutely necessary due to safety concerns.All residents were audited to see if they were using siderails. If they were, all protocols were completed per policy and state/federal regulations. Any concerns were addressed.A facility wide audit was completed to ensure that all residents were receiving all of the medications ordered for them. Any concerns were immediately addressed.The DON or designee will monitor 10 charts weekly to see that siderail useage or non-usage is corrected and being implemented only per policy/procedure. Also, 10 charts will be monitored to see that all medications are being administered according to current physican orders. Any concerns found on these monitorings will be immediately corrected. These monitorings will continue until 4 consecutive weeks of zero negative findings are reallized. Afterwards, random weekly checks will be done. Element # 3What measures will be put into place or what systemic changes will be made to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			deficent practice does not reoccur?At an all staff inservice held 8/9/11 the policy and proceedure for siderails was reviewed. The following was covered: a. Siderail safety b. Siderail order (what, where, when) c. Siderail assessment/ care plan d. Medical need e. Consent/ Waiver f. Flow sheet g. CNA assignment sheet h. Education on siderails (resident and family) i. DiscussionAlso at the inservice the necessity of administering only ordered medications and all ordered medications was reviewed. The policy and procedure for taking a medication order was reviewed. This includes: a). Receiving order b). Checking allergies c). Placing on medication sheet/treatment sheet d). Ordering medication e). Following up on meedication f). Proper notifications g). Stop date (if known) h). Discontinuance of a medication i). Returning medications if appropriate j). Destruction of medication (actual medication on MAR) k). DiscussionAny staff who fail to comply with the points of this inservice will be further educated and or progressively disciplined as appropriate.Element # 4How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurrance program will be put into place;?At the monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Quality Assurance meetings the results of the siderail and medication adminstration monitoring by the DON or designee will be reviewed. Any concerns will have been corrected upon discovery. Any patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. The plan will be monitored weekly by the administrator until resolution.	
F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review and interview the facility failed to check placement or gastric residual before administering tube feedings through a gastrostomy tube (G-tube) for 1 of 5 residents with G-tubes out of a stage two sample of 29. (#33) Findings include: The record for Resident #33 reviewed on 07/15/11 at 1:58 p.m. Diagnoses included, but were not limited to aphasia and acute	F0322	Element # 1What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to see that a resident fed by the feeding tube receives appropriate treatment and services to avoid any complications.Currently, Resident # 33 has tube placement checked prior to any administration of food or medications via tube.Element # 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents fed by tube have the potential to be affected by this	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	respiratory failure. A Social Service Progress note dated 05/04/11 indicated Resident #33, "...unable to communicate..." The most recent recapitulation dated 07/01/11 through 07/31/11, indicated Resident #33 was NPO (nothing by mouth). The most recent recapitulation dated 07/01/11 through 07/31/11, with an original physician's order dated 06/23/11, indicated, "...All med per G-tube and liquid where possible...." The most recent recapitulation dated 07/01/11 through 07/31/11, with an original physician's order dated 05/24/11, indicated, "Jevity 1.5 cal (calorie) at 60cc/hr (cubic centimeters per hour) from 2pm - 10 am...." A care plan title "Feeding Tube," dated 06/23/11 indicated, "Resident has a need for use of a feeding tube...Resident will remain free of complications related to use of a feeding tube...Check residual prior to resuming any enteral feeding, (that has been turned off for 1 hr or greater)...Educate resident/responsible party regarding		finding. All residents who are fed by tube will be monitored at least 3 times weekly on various shifts to be sure all protocol is followed related to adminstration of medications or feeding via tube. This monitoring will be done by the DON or designee. It will continue until 4 consecutive weeks of zero negative findings are realized. Any concerns noted at the time of the monitorings will be corrected on site. Afterwards, random weekly monitorings will continue.Element # 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practices does not reoccur?At the all staff inservice held 8/9/11 the policy/procedure on tube feedings was reviewed. Checking placement of the tube prior to adminstration of feeding or medications was discussed. Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as appropriate.Element # 4How the corrective action(s) will be monitored to ensure the deficient practice will not reoccure, i.e., what quality assurance program will be put into place;?At the montly Quality Assurance meetings the results of the tube feeding monitoring by the DON or designee will be reviewed. Any patterns will be identified. If necessary, an action plan will be written by a committee appointed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	feeding tube...Self-image." During an observation on 07/14/11 at 1:35 p.m., LPN #14 asked CNA #15 to bring the feeding pump out in the hall with Resident #33, so the tube feedings could be initiated at 2:00 p.m. During an observation on 07/14/11 at 2:00 p.m., Resident #33 was in the hallway on the second floor by the nurses station. The feeding pump and pole were next to the resident. The feeding tube was not connected to Resident #33, and the feeding was not running. During an observation on 07/14/11 at 2:35 p.m., LPN #14 lifted Resident #33's shirt while he remained in the hallway and connected the tube feeding to the G-tube and started the feedings. LPN #14 did not check placement of the G-tube and did not check for gastric residual. During an interview on 07/14/11 at 2:40 p.m., LPN #14 indicated, "I know I shouldn't have done that. I should have taken him back to his room." When asked what the policy was on checking for residual and G-tube placement, LPN #14 indicated she		by the administrator. This plan will be monitored weekly until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	knew the importance of checking for placement and residual prior to initiating tube feedings through a G-tube. During an interview on 07/15/11 at 10:55 a.m., CNA #15 indicated the nurse asked him to bring the feeding pole out with the resident so they could start the tube feedings around 2:00 p.m. A current facility policy provided by the Administrator on 07/14/11 at 9:00 a.m., titled, "Tube Feedings, Gastrostomy/Jejunostomy," indicated, "...8. Expose G/J (gastrostomy/jejunostomy) tube and drape with towel. NOTE: Do NOT unnecessarily expose the Resident...10. Verify tube placement via aspiration of gastric/jejunal content with a feeding syringe, re-installing content aspirated, or via (by way of) auscultation of air bolus...." A current facility policy provided by the Administrator on 07/14/11 at 9:00 a.m., titled, "Tube Feeding Closed System Protocol," indicated, "...2. Provide privacy and explain procedure to the resident...." 3.1-44(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0334 SS=E	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview the facility failed to ensure annual consents for influenza vaccinations were obtained prior to administration of annual flu vaccines for 4 of 5 residents reviewed for flu vaccination consents (Residents #19, #85, #84, #9), and failed to administer flu vaccine for 2 of 5 residents reviewed for flu vaccine administration in a Stage 2 sample of 29 (Residents #9 and #40). Findings include: An undated, current facility policy, provided by the Administrator on 7/19/11 at 11:00 A.M., titled	F0334	Element # 1What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to see that all residents/legal representatives are educated as to the side effects of any immunization to be given including that for flu. These flu immunizations offered October 1st thru March 31st. The resident or legal guardian may refuse. The resident's record will reflect this education and administration or refusal.The same is true for pneumococcal immunizations. Except this isn't necessarily recommended October 1st thru March 31st and is not annual but every 5 years.Residents # 19, #85, #84, and #9 have had consents obtained appropriately	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Vaccination Program" indicated: " Purpose - To protect residents against influenza virus by our annual flu vaccine program.... ...Procedure - 1. All residents receiving the influenza vaccine:... ... will have the vaccine recorded on their Health record History Form... All residents receiving an Influenza vaccine will have a signed consent form in their medical record...." On 7/18/11 at 10:00 A.M., the following residents' records were reviewed for annual flu consents and immunizations: Resident #19, the Immunization Record indicated he had refused both the flu and pneumonia vaccines. The record lacked a signed refusal or consent form. Resident #85, received a flu vaccination on 3/13/11. The record lacked documentation of a signed consent. Resident #84 received the flu vaccine on 11/16/10. The record lacked documentation of a consent for flu vaccination. Resident #9's record lacked an Immunization Record, lacked documentation of flu vaccine administration, and lacked documentation of consent for the flu vaccination.		for flu vaccine. Residents # 9 and # 40 will receive flu vaccine at the time the physican orders it to be given. Also,, they will receive pneumonia vaccine as well.Element # 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this finding. A spreadsheet has been created to be sure all residents have the required education and offer of all proper vaccines including those for flu and pneumonia. Consent forms will be part of this process. Any resident who has an order for flu or pneumonia immunizations and who desires them to be given will receive them (unless contraindicated due to a medical reason). This will be monitored monthly by the DON or designee. Residents will be added to the "tracker file" spreadsheet upon admission. This monitoring will be ongoing. Element # 3What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?At an all staff inservice held 8/9/11 the necessity of all appropriate immunizations was reviewed. The process of education, consent, and administration were discussed. Any staff who fail to comply with the points of this inservice will be further educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #40's record had a signed consent form which indicated she wanted the flu and pneumonia vaccines administered, signed on 10/30/10. The record lacked documentation of administration of a flu or pneumonia vaccine. During an interview with the Administrator on 7/19/11 at 8:30 A.M., he indicated Resident #40 did not receive the vaccines, the facility's supply had run out. During an interview with the DON (Director of Nursing) on 7/19/11 at 10:30 A.M., she indicated Resident #40 did not receive either vaccine. The DON also indicated she was unable to determine if Resident #9 received the flu vaccine. Also at that time, the DON indicated no other consent (or refusal) forms had been found. 3.1-13(a)		and or progressively disciplined as appropriate. Element # 4How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place;?At the monthly Quality Assurance meetings the results of the monthly immunization "tracker file" spreadsheet monitoring by the DON or designee will be reviewed. Any concerns will be addressed. Any patterns will be identified. If necessary, an action plan will be written by a committee appointed by the administrator. The plan will be monitored weekly by the adminstrator until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and interview the facility failed to ensure insulins were not expired in 2 of 5 medication carts checked for expired medications. Findings include: A current facility policy dated 10/07 and titled, "Medication Storage" and provided by the administrator indicated: "Procedures: ... 14. Outdated, contaminated, discontinued or deteriorated medications ... are	F0425	Element # 1What corrective action(s) will be accomplished for those residents found to have been affected by the deficent practice?It is the policy of this facility to see that routine, emergency drugs, and biologicals are available to the residents as per the resident's need/physican order. All of this is available through an agreement with a licensed pharmacist. The pharmacy will provide monitoring and consultation. This includes checking dates on drugs for expiration.Currently all Novolog	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immediately removed from stock ..." A current facility policy dated 10/07 and titled, "Medications with Special Expiration Date Requirements" and provided by the administrator indicated, "Novolog vials expire opened, 28 days." Observation of the medication cart on the 3rd floor West Hall on 7/18/11 at 10:30 A.M. indicated an open vial of Novolog (insulin) dated 6/16/11. Observation of the medication cart on the 3rd floor North Hall on 7/18/11 at 10:30 A.M. indicated an open vial of Novolog (insulin) dated 6/17/11. An interview with LPN #8 on 7/18/11 at 10:30 A.M. indicated open insulins expire after 28 days. 3.1-25(o)		insulin is not used past the 28 day expiration period (after opening).Element # 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?Any residents on Novolog insulin has the potential to be affected by this finding. The DON or designee will check all medication carts at least once weekly for residents on Novolog insulin to be sure it is dated when opened and is not used after a 28 day period. This monitoring will continue until 4 consecutive weeks of zero negative findings are realized. Afterwards, random checks will be made.Element # 3What measures will be put into place or what systemic changes will be made to ensure that the deficent practice does not reoccur?At an all staff inservice held 8/9/11 the fact that some medications have a specific amount of days they can be used after they are opened will be discussed. Futher, the fact that medications which need to be opened must also be dated was reviewed. Any staff who fail to comply with the points of this inservice will be further educated and/or progressively disciplined as appropriate.Also covered in this inservice will be the fact that no medications are to be "preset". Medications are to be prepared or "poured" at the time of administration. Any staff who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			fails to comply with the points of this inservice will be further educated and or progressively disciplined as appropriate.Element # 4How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place;?At the monthly Quality Assurance meetings the monitoring of Novolog insulin checks by the DON or designee will be reviewed. Any concerns will be corrected as found. However, any patterns will be identified and any needed education will be done by the DON or designee as found to be needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview the facility failed to ensure medications were labeled with open dates for 2 of 5 medication carts checked for open dates and failed to ensure controlled (narcotic) medications were not preset for 1 of 5 medication carts checked for preset	F0431	Element # 1What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to see that a pharmacy is working to provide services to the facility to meet the needs of the residents for any ordered drugs or biologicals.Curently, all	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications. Findings include: A current facility policy dated 10/07 and titled, " Medication Storage" and provided by the Administrator on 7/19/11 at 8:00 A.M. indicated, "Procedures, ... 12. ...Date insulin vials when first opened... ...2. Controlled medications must be stored separately from non-controlled medications." A current facility policy dated 10/07 and titled, "Medication Administration" and provided by the Administrator on 7/19/11 at 8:00 A.M. indicated, ...Medication Administration: 1. Medications are administered in accordance with written orders of the Prescriber... ...4. Medications are to be administered at the time they are prepared. Observation of the medication cart on the 3rd floor North Hall on 7/18/11 at 10:30 A.M. revealed 3 vials of Lantus (insulin) without open dates. Observation of the medication cart on the 2nd floor North Hall on 7/18/11 at 10:45 A.M. revealed 1 vial of Lantus (insulin) without open dates.		medications opened before use at the facility are dated as to the opened date and destroyed timely per opened medication policy. Further, no ordered narcotics nor any other medications are present prior to actual adminstration.Element # 2How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this finding. Going forward the DON or designee will monitor all medication carts at least once weekly for resients on Lantus insulin to be sure it is dated when opened and is not used past the expiration period for opened medications. This monitoring will continue until 4 consecutive weeks of zero negative findings are realized. Afterwards, random weekly checks will be made. Also, during this monitoring the DON or designee will also check to see that no medications are "preset" prior to their actual administration. This monitoring will continue until 4 consecutive weeks of zero negative findings are realized. Afterwards, random weekly checks will be done. Element # 3What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?At an all staff inservice held 8/9/11 the fact that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Observation of the medication cart on the 2nd floor South Hall on 7/18/11 at 10:45 A.M. revealed LPN # 11 had placed a controlled medication (Oxycontin) in a medication cup in the top drawer of the medication cart. During an interview at that time, the LPN indicated she had pulled the medication in error for 10:00 A.M. but the resident was not due to get the medication until 4:00 P.M. 3.1-25(j) 3.1-25(n)		some medications have a specific amount of days they can be used after they are opened will be discussed. Futher, the fact that medications which need to be opened must also be dated was reviewed. Any staff who fail to comply with the points of this inservice will be further educated and/or progressively disciplined as appropriate.Also covered in this inservice will be the fact that no medications are to be "preset". Medications are to be prepared or "poured" at the time of administration. Any staff who fails to comply with the points of this inservice will be further educated and or progressively disciplined as appropriate.Element # 4How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place;?At the monthly Quality Assurance meetings the monitoring of opened medications being dated and not used past their expired number of days to be used will be reviewed. Additionally, monitoring by the DON or designee for "preset" drugs will be reviewed. Any findings will be corrected upon finding. The DON or designee will perform any necessary teaching or progressive disciplines as appropriate.	